

ACT 421 CHILDREN'S MEDICAID OPTION (TEFRA/Katie Beckett)

HEALTH RECORD REQUEST FORM

Name of Child: _____

Name of Parent/Legal Guardian: _____

Contact Phone Number: _____

Please submit supporting documentation and provider information for all reported diagnoses/treatments. If you have any questions about this form, please reach out to your Local Governing Entity (LGE). If you need more space use question 11 or attach additional pages.

DIAGNOSIS INFORMATION

1. What are the child's current diagnoses?

Diagnosis	Name/Title of Person Who Made the Diagnosis	Date of Diagnosis (mm/dd/yyyy)

2. Communication and Understanding – List any speech/language testing the child has participated in:

Test Name		
Date of Test (mm/dd/yyyy)		
Expressive Language Score (if not known or available, leave blank)		
Receptive Language Score (if not known or available, leave blank)		
Name of Person Giving Test		
Address of Person Giving Test		

3. Learning and Comprehension – List any intelligence testing the child has participated in:

Test Name		
Date of Test (mm/dd/yyyy)		
Full Scale IQ		
Name of Person Giving Test		
Address of Person Giving Test		

4. Providers – List all current providers and their contact information below. You can sign an *Authorization to Release or Obtain Health Information Form (HIPAA 202L)* to authorize LDH to obtain necessary medical records directly from the providers (physicians, home health, social service, etc.).

Name of Provider	Address	Phone Number	Specialization

5. Therapy – List any therapies (occupational, physical, speech, etc.) in which the child participates:

Name of Provider			
Address			
Phone Number			
Type of Therapy			
Place of Therapy <i>(school, home, clinic, etc.)</i>			
Number of Sessions <i>(per week)</i>			

6. Hospitalizations – Has the child been hospitalized in the past two years? ☐ Yes ☐ No If yes, please provide the following information:

Name of Hospital			
Address of Hospital			
Reason for Admission			
Date of Admission <i>(mm/dd/yyyy)</i>			
Date of Discharge <i>(mm/dd/yyyy)</i>			

7. Current Medications – list all prescription medications (including chemotherapy) the child routinely takes:

Name of Medication	How Often	How Taken	Side Effects

8. Current Medical/Nursing Care Needs – please indicate the child’s current care needs, how often they are required, their start date, and amount of help the child needs or if the child is independent with needed care:

Care Needed		How Often	Start Date (mm/dd/yyyy)	Amount of Help Needed
<input type="checkbox"/>	Apnea monitor			
<input type="checkbox"/>	Nebulizer			
<input type="checkbox"/>	Oxygen			
<input type="checkbox"/>	Suction			
<input type="checkbox"/>	Tracheostomy care			
<input type="checkbox"/>	Ventilator			
<input type="checkbox"/>	IV line indwelling			
<input type="checkbox"/>	Total Parenteral Nutrition (TPN)			
<input type="checkbox"/>	Bowel program			
<input type="checkbox"/>	Dialysis			
<input type="checkbox"/>	Ostomy care			
<input type="checkbox"/>	Tube feeding			
<input type="checkbox"/>	Urinary catheter care			
<input type="checkbox"/>	Other:			
<input type="checkbox"/>	Other:			
<input type="checkbox"/>	Other:			

9. School – Does the child have an Individualized Education Program (IEP)? ☐ Yes ☐ No

Is the child enrolled in special education? ☐ Yes ☐ No

If yes to either of these questions, please provide the following information:

Name of School			
Grade Level			
Name of Teacher			
Address			
Phone Number			

10. If you have any of the following for your child, please indicate below and attach to this application:

Assessment/Document		Date of Completion <i>(mm/dd/yyyy)</i>	Name/Title of Person Who Completed Document
<input type="checkbox"/>	Individualized Education Plan (IEP)		
<input type="checkbox"/>	Inventory for Client and Agency Planning		
<input type="checkbox"/>	Individualized Family Services Plan (IFSP) with the Battelle Development Inventory (BDI)		
<input type="checkbox"/>	Ages & Stages Questionnaire		

11. If you have any additional information, please include it below:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Form completed by:

Signature

Print Name

Date _____